

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08219

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08206

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Churchville (Rural)				c. LENGTH OF STAY IN lb Street (Rural)			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Md. Route #136 (Priest Ford Road)				d. STREET ADDRESS Old Forge Hill Road			
3. NAME OF DECEASED (Type or print) Peter Francis Ackley				4. DATE OF DEATH June 20, 1967			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH October 24, 1906	
9. AGE (In years last birthday) 60 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Logistics		10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Peter Akelaitis			
14. MOTHER'S MAIDEN NAME Eva Judovireius				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW #2			
16. SOCIAL SECURITY NO. 181-05-8880				17. INFORMANT (Sister) 457-4673 RFD #2, Box #291 Mrs. Anna L. Rohos Street, Md. 21154			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture of Skull DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Auto Accident			
20c. TIME OF INJURY Month, Day, Year 730 PM 6-20 1967				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Churchville H2. Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Gerald C. Palmer				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Gerald C. Palmer, M.D., S. Main St., Bel Air, Maryland 21014				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22. DATE SIGNED June 20, 1967							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 23, 1967		23c. NAME OF CEMETERY OR CREMATORY St. Ignatius Cath. Ch. Cem. Hickory, Harf. Co. Md.		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR Joseph William Foster				25. REC'D BY REGISTRAR W. Broadway & Williams		25b. REGISTRAR'S SIGNATURE Charles Judge	
25c. ADDRESS Bel Air, Maryland 21014				DATE June 22 1967			

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08220

CERTIFICATE OF DEATH

082207

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harpe-de-Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Abingdon</u>	
c. LENGTH OF STAY IN lb <u>3 days</u>		d. STREET ADDRESS <u>3018 Phila Rd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Albert</u> Middle <u>James</u> Last <u>Barnes</u>		4. DATE OF DEATH Month <u>6</u> Day <u>3</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 10, 1920</u>
9. AGE (In years last birthday) yrs. <u>46</u>		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck driver</u>		12. KIND OF BUSINESS OR INDUSTRY <u>SELF</u>	
13. BIRTHPLACE (Country & State, or foreign country) <u>Va.</u>		14. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. FATHER'S NAME <u>John Barnes</u>		16. MOTHER'S MAIDEN NAME <u>Hattie Frazier</u>	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		18. SOCIAL SECURITY NO. <u>215-14-9632</u>	
19. INFORMANT <u>Betty Jane Barnes</u>		Address <u>somewhere</u>	
20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>A.S.C.V.D.</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>6-1-67</u> , 19 <u>67</u> to <u>6-3</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>6/3</u> , 19 <u>67</u> and that death occurred at <u>5:00 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Edward C. Leo</u>		22b. DATE SIGNED <u>6/3/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Edward C. Leo, M.D.</u>		22d. ADDRESS <u>Harpe de Grace, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>June 6, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>		23d. LOCATION (City or Town) (County) (State) <u>Bel Air Harford Md</u>	
24. FUNERAL DIRECTOR <u>Howard K. McComas & Son, Abingdon, Md. 21009</u>		25a. REC'D BY REGISTRAR <u>JUN 6 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>James J. Judge</u>		25c. REGISTRAR'S SIGNATURE <u>James J. Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

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CHIEF OF DEPT.

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[Faint, mostly illegible text and markings covering the majority of the page, possibly bleed-through from the reverse side.]

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08221

CERTIFICATE OF DEATH

08208

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u>		c. LENGTH OF STAY in 1b <u>21 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hartford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Margaret Louise Beall</u> First Middle Last		4. DATE OF DEATH Month <u>June</u> Day <u>4</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 2, 1919</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cashier</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Food Store</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Easton, Talbot Co., Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harry N. Bailey</u>		14. MOTHER'S MAIDEN NAME <u>Goldie Notts</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>218-01-5786</u>	
17. INFORMANT <u>Husband (838-3449)</u> Address <u>Mr. Alexander E. Beall 3 Wheel Rd., RTD#2</u> <u>BEL Air, Maryland 21014</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HEMORRHAGE - General</u> <u>292N</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>APLASTIC ANEMIA</u> DUE TO (c) <u>Leukemia</u>			INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>9 mo</u> <u>1 mo</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>o.m.</u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>5-15</u> , 19 <u>67</u> , to <u>6-4</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>6-4</u> , 19 <u>67</u> , and that death occurred at <u>11:35</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Dudley Phillips</u>		22b. DATE SIGNED <u>6/5/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dudley Phillips MD</u>		22d. ADDRESS <u>DARLINGTON Md 21034</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>JUNE 8, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>BEL Air Memorial Gardens</u>	23d. LOCATION (City or Town) (County) (State) <u>BEL Air, Hartford Co., Maryland 21014</u>
24. FUNERAL DIRECTOR <u>Joseph William Foster</u> <u>W. Broadway & Williams St.</u> <u>BEL Air, Maryland 21014</u>		25a. REG'D BY REGISTRAR <u>JUN 6 1967</u> DATE	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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George F. 178

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
Item #8 Film #G390 7/3/67 pc											
CERTIFICATE OF DEATH											
08222											
08209											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Baltimore</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Citizens Housing Assoc</u>				c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Joppa</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Beyer Rose Rebecca</u>						d. STREET ADDRESS <u>911 Mountain Rd</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Rose Rebecca Beyer</u>						4. DATE OF DEATH Month Day Year <u>June 23 1967</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <u>Aug 21 - 1891</u>		9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Forest Hill MD</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>George R. Pearce</u>						14. MOTHER'S MAIDEN NAME <u>Esther Smith</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>219-10-1906</u>		17. INFORMANT <u>Herman Beyer Jr</u> Address <u>Joppa MD</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO <u>H. A. S. C. V. D</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> (c) <u></u>										INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Diabetes Mellitus & (L) Lung Lesion</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>3/16/67</u> , to <u>6/23/67</u> , that (I) was saw the deceased alive on <u>6/23/67</u> , and that death occurred at <u>9:30</u> M, from causes and on the date stated above.											
22a. SIGNATURE <u>Charles J. Foley Jr.</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>CHARLES J. FOLEY JR.</u>						22d. ADDRESS <u>HAVRE DE GRACE, MD.</u>					
23a. BURIAL, CREMATION, REMOVAL <u>Burial</u>		23b. DATE THEREOF <u>June 27</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fork, Methodist</u>		23d. LOCATION (City or Town) (County) (State) <u>Fork Baltimore MD</u>					
24. FUNERAL DIRECTOR <u>W H Archer</u>						ADDRESS <u>Baltimore</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
						DATE <u>JUN 27 1967</u>					

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STANDARD OF DATA

DO NOT WRITE ON VERTICAL MARGIN OR OVERPRINTED AREA

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08210

1. PLACE OF DEATH a. CDUNTY <i>Harford</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. CDUNTY <i>Harford</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Havre de Grace</i>		c. LENGTH OF STAY IN 1b <i>28 days</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Citizens Nursing Home</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>William</i> Middle <i>V.</i> Last <i>Brown</i>		4. DATE OF DEATH Month <i>6</i> Day <i>11</i> Year <i>1967</i>	
5. SEX <i>Male</i>	6. CDLOR OR RACE <i>Negro</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 27, 1889</i>
9. AGE (In years last birthday) <i>78 yrs.</i>		IF UNDER 1 YEAR Months <i>7</i> Days <i>11</i>	IF UNDER 24 HRS. Hours <i>11</i> Min. <i>19</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Carpenter (retired)</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Self Employed</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Perryman Md.</i>
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		13. FATHER'S NAME <i>James E. Brown</i>	
14. MOTHER'S MAIDEN NAME <i>Martha K. Brown</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	
16. SOCIAL SECURITY NO. <i>212-12-4035A</i>		17. INFORMANT <i>Mrs. Pearl S. Brown - Havre de Grace, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i> <i>420.0</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic Heart disease</i> (c) <i>Generalized Arteriosclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Fracture of Left Hip - Treated</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>5/15</i> , 19 <i>67</i> , to <i>6/11</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>6/10</i> , 19 <i>67</i> , and that death occurred at <i>M</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>George T. Stansbury</i>	M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>6/12/67</i>	
22c. PHYSICIAN'S NAME (Type) <i>George T. Stansbury, M.D.</i>	22d. ADDRESS <i>569 Revolution St., Havre de Grace, Md.</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>6-15-1967</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Union Methodist Cem.</i>	23d. LOCATION (City, town or county) (State) <i>Aberdeen Harford Co. Md.</i>
24. FUNERAL DIRECTOR <i>Otelia J. Bullock, Havre de Grace, Md.</i>	ADDRESS <i>556 E. Lane St.</i>	25a. REC'D BY REGISTRAR <i>JUN 14 1967</i>	25b. REGISTRAR'S SIGNATURE <i>Charles J. [Signature]</i>

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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THE GENERAL OFFICE OF HEALTH

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GENERAL OFFICE OF HEALTH

CERTIFICATE OF DEATH

08224

08211

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>	
c. LENGTH OF STAY IN TB <u>7 hrs.</u>		d. STREET ADDRESS <u>10 W. INCA ST.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hartford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Baby Girl Brownen</u>		4. DATE OF DEATH Month <u>June</u> Day <u>25</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 25, 1967</u>
9. AGE (In years lost birthday) yrs. <u>7</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u> Hoyt J. Brownen</u>		14. MOTHER'S MAIDEN NAME <u>J. Gerie Ezell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Hoyt J. Brownen, Aberdeen Md. 21001</u>		18. ADDRESS <u>Aberdeen Md. 21001</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>immaturity</u> DUE TO (b) <u>Premature Delivery</u> DUE TO (c) <u>Premature rupture of membranes</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>June 25, 1967</u> to <u>June 25, 1967</u> , that (I) (we) last saw the deceased alive on <u>June 25, 1967</u> , and that death occurred at <u>10:35 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>John A. Amore</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
<u>Burial</u>	<u>JUNE 26, 1967</u>	<u>Angel Hill, Can.</u>	<u>Havre de Grace, Md.</u>
24. FUNERAL DIRECTOR <u>R. Madison Mitchell, Havre de Grace, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>JUN 28 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles J. Judge</u>		25c. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

08230

Hartford

Harv. de Grace 7 hr

Hartford Memorial Hospital 10 W. Inca St

Girl Brownish

1340

Female White

Mid

Aberdeen

Hartford

June 22 61

1047

June 22 61

June 22 61

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
08225 CERTIFICATE OF DEATH 08212									
1. PLACE OF DEATH a. COUNTY Harford MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Churchville			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Churchville				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Route #1, Box 518					d. STREET ADDRESS Route #1, Box 518			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First JOSEPH		Middle VERNER		Last BURNS		4. DATE OF DEATH Month June Day 15 Year 19 67	
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 29 Jan. 1906		9. AGE (In years last birthday) 61 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Automotive Mechanic		10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt. APG.		11. BIRTHPLACE (County & State, or foreign country) Pittsburgh, Penna.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME James Burns (D)					14. MOTHER'S MAIDEN NAME Sarah Graham (D)				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW-II 217-01-4366		17. INFORMANT Wife, Same as 2 C & D					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Thrombosis 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. OUE TO (b) Coronary Arteriosclerosis OUE TO (c) Arteriosclerosis								INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hrs 1 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Acute Rheumatism								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from June 10, 1967 , to June 15, 1967 , that (I) (we) last saw the deceased alive on June 10, 1967 , and that death occurred at 7:30 AM , from the causes and on the date stated above.									
22a. SIGNATURE D. Ralph Horkey				22b. DATE SIGNED 6/15/67				22c. PHYSICIAN'S NAME (Type) D. Ralph Horkey	
22d. ADDRESS Churchville				22e. M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. ADDRESS Churchville			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 19 June 67		23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens, Bel Air Maryland		23d. LOCATION (City, town or county) (State)			
24. FUNERAL DIRECTOR Walter McCowan Sr.				24a. ADDRESS Tarring Funeral Home, Aberdeen, Md.		25a. REC'D BY REGISTRAR JUN 19 1967		25b. REGISTRAR'S SIGNATURE Charles J. Jones	

00000

Home St. Box 518

Home St. Box 518

June 15

Bureau

Verona

Verona

29 Jan. 1906

James Buchanan

Automotive Mechanics, E. Nov. Apr. Pittsburgh, Penna. U.S.A.

James Burns (D)

James Burns (D)

217-1-100-110, Same as S. D. 1-10

217-1-100-110, Same as S. D. 1-10

James Buchanan
James Buchanan

James Buchanan

June 15

June 15

Churchville

James Buchanan
James Buchanan

19 June 04, 701 Ate Memorial Garden, Del. Air Station

Turning General Home 11-18-1907

11-18-1907

08226

CERTIFICATE OF DEATH

08213

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u>		c. LENGTH OF STAY IN lb <u>1 mon. & 20 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Port Deposit</u> <u>072</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Citizens Nursing Home</u>				d. STREET ADDRESS <u>Mt. Anarat Farms</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Louie</u> Middle <u>M. S.</u> Last <u>Carlisle</u>				4. DATE OF DEATH Month <u>June</u> Day <u>15</u> Year <u>19 67</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cau.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 26, 1885</u>		9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (County & State, or foreign country) <u>New Hampshire</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Frederick Louis Small</u>				14. MOTHER'S MAIDEN NAME <u>Emma Tanna Crane</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>047-30-7550</u>		17. INFORMANT <u>Mrs. Henry Roberts, Port Deposit, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>1810</u> <u>Cerebral Arteriosclerosis</u> DUE TO (b) <u>Decomposed Hypertensive Arteriosclerosis</u> DUE TO (c) <u>Arteriosclerosis C. & C.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u> <u>10 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11-4</u> , 19 <u>64</u> , to <u>6-15</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>6-15</u> , 19 <u>67</u> , and that death occurred at <u>3:45 AM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>G. H. Richards Jr. M.D.</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>6/16/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>G. H. Richards Jr. M.D.</u>				22d. ADDRESS <u>Port Deposit, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>June 19, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Starr King Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Jefferson, N. H.</u>	
24. FUNERAL DIRECTOR <u>Lee A. Patterson & Son, Perryville, Md.</u>				25a. REC'D BY REGISTRAR <u>JUN 26 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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05230

STATE OF TEXAS

County

County

County

Survey of

Section 6

Section 6

(Section 6, Block 1)

(Section 6, Block 1)

Block

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Block

Block

Section 6, Block 1

Section 6, Block 1

Section 6, Block 1

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Section 6, Block 1

Section 6, Block 1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08227

08214

1. PLACE OF DEATH a. COUNTY Harford MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Churchville c. LENGTH OF STAY IN b. 25 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Cool Branch Road (R.F.D.#1, Box#150)				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Harford c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Churchville d. STREET ADDRESS Cool Branch Road (R.F.D.#1, Box#150)			
3. NAME OF DECEASED (Type or print) Sarah Elizabeth Close		First Middle Last Sarah Elizabeth Close		4. DATE OF DEATH Month Day Year June 4, 1967			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 25, 1919		9. AGE (In years last birthday) 47 yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Homemaker		11. BIRTHPLACE (County & State, or foreign country) Harford Co., Maryland			
13. FATHER'S NAME Charles Wesley Michael			14. MOTHER'S MAIDEN NAME Grace Hamway				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 213-18-9546		17. INFORMATION (Husband) 734-7537 Address RFD#1, Box#150 Mr. Steve W. Close Churchville, Md. 21028			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Metastatic Carcinoma - lungs, bones, & cerebrum Conditions, if any, which gave rise to immediate cause (b) Carcinoma of left breast (a), stating the underlying cause last. (c)					INTERVAL BETWEEN ONSET AND DEATH 1 yr. 27 mos.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M., from the causes and on the date stated above.							
22a. SIGNATURE Peter P. Rodman, M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED June 4, 1967			
22c. PHYSICIAN'S NAME (Type) Peter P. Rodman, M.D.		22d. ADDRESS 82-0486 2949 (hmc) 8 Low St., Aberdeen, Md. 21001					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 7, 1967		23c. NAME OF CEMETERY OR CREMATORY St. Mary's Episcopal Ch. Cem. Emmorton, Harf. Co., Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Joseph William Foster		W. Broadway & Williams St. Bel Air, Maryland 21014		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JUN 6 1967			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Joseph William Foster

1832

1832

Marion

Marion

Marion

Cherokee

Cherokee

Cherokee

1001 Branch Road (N.W.), Box 150

1001 Branch Road (N.W.), Box 150

June 4, 1967

June 4, 1967

July 25, 1919

July 25, 1919

Marion Co., Maryland

Marion Co., Maryland

Marion Co., Maryland

Charles Wesley Bishop
(inspired) 1919-1922
1001 Branch Road, Box 150
Cherokee, N.C. 28719

Charles Wesley Bishop

1001 Branch Road

1001 Branch Road

1001 Branch Road, Box 150
Cherokee, N.C. 28719

June 4, 1967

June 4, 1967

June 4, 1967

June 4, 1967

June 4, 1967

June 4, 1967

08228

CERTIFICATE OF DEATH

08215

1. PLACE OF DEATH a. COUNTY <u>MD - Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURDE GRACE</u>			c. LENGTH OF STAY IN lb <u>7 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FOREST HILL</u> <u>12.1</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HARFORD Memorial Hospital</u>				d. STREET ADDRESS <u>U.S. Rt. 24</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Bertha W. Daughton</u>				4. DATE OF DEATH Month <u>June</u> Day <u>27</u> Year <u>1967</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/2/1891</u>	
				9. AGE (In years last birthday) yrs. <u>76</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Md. Jarrettsville</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Charles H. Amrein</u>				14. MOTHER'S MAIDEN NAME <u>Mary A. Eicholtz</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-26-8929</u>		17. INFORMANT <u>Robert L. Daughton</u>		Address <u>419 Parke St. Aberdeen, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u> </u> (c) <u>Chr. arterio-sclerotic cardio-vasc. disease 10yr?</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>21001</u> INTERVAL BETWEEN ONSET AND DEATH <u>Such an</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 21</u> , 19 <u>67</u> , to <u>June 27</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>June 27</u> , 19 <u>67</u> , and that death occurred at <u>9:20</u> A.M., from causes and on the date stated above.							
22a. SIGNATURE <u>Willard P. Hudson</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <u>6/27/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>Willard P. Hudson, M.D.</u>				22d. ADDRESS <u>Forest Hill, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/30/1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Jarrettsville</u>		23d. LOCATION (City or Town) (County) (State) <u>Jarrettsville, Md.</u>	
24. FUNERAL DIRECTOR <u>Charles E. Kurtz</u>				ADDRESS <u>Jarrettsville, Md.</u>		25a. REC'D BY REGISTRAR <u>21084</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>JUN 29 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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08229

CERTIFICATE OF DEATH

08216

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAYBE de Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Nottingham Pa.</u>	
c. LENGTH OF STAY IN 1b <u>6 Days</u>		d. STREET ADDRESS <u>P.F.D. Nottingham Pa.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HARFORD Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Benjamin DAVIS</u>		4. DATE OF DEATH Month Day Year <u>June 12 1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Unk</u> <u>About 72</u>
9. AGE (In years and birth day) <u>Unk.</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unk.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Pa.</u>		12. CITIZENSHIP OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unk.</u>		14. MOTHER'S MAIDEN NAME <u>Unk.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Unk.</u>		16. SOCIAL SECURITY NO. <u>222-20-7842A</u>	
17. INFORMANT <u>R.D. Nottingham</u>		18. <u>Calvert Manor Nursing Home</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO (b) <u>Arteriosclerotic Cardiovascular disease</u> DUE TO (c) <u>Cardiac failure</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Brain Syndrome due to Senility</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>June 6th 1967</u> to <u>June 12 1967</u> , that (I) (we) last saw the deceased alive on <u>June 12 1967</u> , and that death occurred at <u>11:00</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Edmund C. Loo, M.D.</u>		22b. DATE SIGNED <u>6/12/67</u>	22c. PHYSICIAN'S NAME (Type) <u>Edmund C. Loo, M.D.</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>6-17-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>West Nottingham Cem. Calora Cecil Md.</u>
23d. LOCATION (City or Town) (County) (State) <u>Calora Cecil Md.</u>		23e. REC'D BY REGISTRAR <u>James E. McHallen</u>	23f. REGISTRAR'S SIGNATURE <u>Rising Sun Md.</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08230

CERTIFICATE OF DEATH

08217

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen Proving Ground		c. LENGTH OF STAY IN lb 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kirk Army Hospital				d. STREET ADDRESS 25 Liberty Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Starlette Kay Draper				4. DATE OF DEATH June 8 1967			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1 July 1962	
9. AGE (In years last birthday) 4 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NA		10b. KIND OF BUSINESS OR INDUSTRY N/A		11. BIRTHPLACE (County & State, or foreign country) Jackson, Michigan	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Milton E. Draper Jr			
14. MOTHER'S MAIDEN NAME Diane L. Stack				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)			
16. SOCIAL SECURITY NO. N/A				17. INFORMANT Father Address (Same as above)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Convulsive Disorder DUE TO (b) 057.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Mental Deficiency, moderate to severe							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the informant) attended the deceased from 8 June 1967 , to 8 June 1967 , that (I) (we) last saw the deceased alive on 8 June 1967 , and that death occurred at 7:45 PM , from causes and on the date stated above.							
22a. SIGNATURE Leland Wight				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 8 June 1967	
22c. PHYSICIAN'S NAME (Type) LELAND WIGHT, CPT, MC				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 10 June 1967		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION (City or Town) (County) (State) Jackson, Michigan	
24. FUNERAL DIRECTOR Kenneth B. Camp				ADDRESS Tarring Funeral Home		25. REGD BY REGISTRAR JUN 14 1967	
						25. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

2023

Department of Health

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
08231											
1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Harford</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harre de Grace</i>				c. LENGTH OF STAY IN 1b <i>Lifetime</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harre de Grace</i>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>569 Girard Street</i>						d. STREET ADDRESS <i>569 Girard Street</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Carrie</i> First			<i>B.</i> Middle			<i>Durbin</i> Last			4. DATE OF DEATH Month <i>6</i> Day <i>23</i> Year <i>1967</i>		
5. SEX <i>Female</i>		6. COLOR OR RACE <i>Negro</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>June 8, 1879</i>		9. AGE (In years last birthday) <i>88</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Private Family</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Harre de Grace, Md.</i>			12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		
13. FATHER'S NAME <i>Zachariah Brown</i>						14. MOTHER'S MAIDEN NAME <i>Cassie White</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>				16. SOCIAL SECURITY NO. <i>217-12-5643</i>		17. INFORMANT <i>Mr. Albert Durbin</i>			Address <i>569 Girard St. Harre de Grace, Md.</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <i>Arteriosclerotic Cardiovascular disease</i> DUE TO (c) <i>Generalized Arteriosclerosis</i>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
MEDICAL CERTIFICATION											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>May 19, 1964</i> , to <i>June 23, 1967</i> , that (I) (we) last saw the deceased alive on <i>June 22, 1967</i> , and that death occurred at <i>A. M.</i> from the causes and on the date stated above.											
22a. SIGNATURE <i>George T. Stansbury</i> M.D.								22b. DATE SIGNED <i>June 24, 1967</i>			
22c. PHYSICIAN'S NAME (Type) <i>George T. Stansbury</i>						22d. ADDRESS <i>569 Revolution St. Harre de Grace, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE THEREOF <i>June 28, 1967</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. James A.M.E. Cemetery</i>			23d. LOCATION (City, town or county) (State) <i>Harre de Grace, Harford Co. Md.</i>			
24. FUNERAL DIRECTOR <i>Otelia J. Bullock</i> ADDRESS <i>556 Lerma St. Harre de Grace, Md.</i>						25a. REC'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE			
						DATE <i>JUN 28 1967</i>					

12530

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. See pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08232

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08219

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace			c. LENGTH OF STAY IN 1b D6A		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Joppa		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Harford Memorial Hospital				d. STREET ADDRESS 1213 Joppa Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First LONNIE Middle Payton Last FERREN				4. DATE OF DEATH Month June Day 8 Year 19 67			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH May 24, 1905	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Boiler Operator		10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt. (retired)		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME David W. Ferren				14. MOTHER'S MAIDEN NAME Anne Davis			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 705-09-7416		17. INFORMANT James R. Medley Address 604 Bungardner Rd. Joppa, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL EXAMINER'S SIGNATURE Gerald C Palmer M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> Bel Air, Md. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) 6-8-67					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 10, 1967		23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Garden		23d. LOCATION (City or Town) (County) (State) Bel Air Harford Md.	
24. FUNERAL DIRECTOR Howard K. McComas & Son				ADDRESS Abingdon, Md.		25a. REC'D BY REGISTRAR DATE JUN 12 1967	
				25b. REGISTRAR'S SIGNATURE Charles Judge			

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08233

CERTIFICATE OF DEATH

08220

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MARYLAND b. COUNTY HARFORD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAURE de Grace		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Abingdon		12/1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HARFORD Memorial Hospital				d. STREET ADDRESS Box 123		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Frank Middle DAVID Last FLORA				4. DATE OF DEATH Month June Day 2 Year 1967			
5. SEX MALE	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 2, 1924	9. AGE (In years last birthday) yrs. 42	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Factory worker		10b. KIND OF BUSINESS OR INDUSTRY rubber		11. BIRTHPLACE (County & State, or foreign country) Burdine, Ky.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joe Flora				14. MOTHER'S MAIDEN NAME Flora Dandy			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WWII		16. SOCIAL SECURITY NO. 404-34-2139		17. INFORMANT Address Carl E. Flora, 112 Laura Ave., Dayton, Ohio			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Extensive anterior myocardial infarction DUE TO (b) Coronary thrombosis DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH 2 days 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 1st, 1967 to June 2, 1967 that (I) (we) last saw the deceased alive on June 2, 1967 , and that death occurred at 10:21 PM from causes on and on the date stated above.							
22a. SIGNATURE Edward C. Loo, M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6/2/67			
22c. PHYSICIAN'S NAME (Type) Edward C. Loo, M.D.		22d. ADDRESS Haure de Grace, Ind.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF June 3, 1967		23c. NAME OF CEMETERY OR CREMATORY Craft & Polly Funeral Home		23d. LOCATION (City or Town) (County) (State) Jenkins, Ky.	
24. FUNERAL DIRECTOR Howard K. McComas & Son, Abingdon, Md. 21009				25a. REC'D BY REGISTRAR JUN 6 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

0000

RECEIVED ON 10/10/10

00000

10/10/10
10/10/10
10/10/10

08234

CERTIFICATE OF DEATH

08221

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u>		c. LENGTH OF STAY IN 1b <u>4 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Rebecca</u> Middle <u>Snyder</u> Last <u>Gorrell</u>		4. DATE OF DEATH Month <u>June</u> Day <u>22</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 14, 1897</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	9. AGE (In years last birthday) yrs. <u>70</u>
11. BIRTHPLACE (County & State, or foreign country) <u>Bel Air, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Christopher Truman Snyder</u>		14. MOTHER'S MAIDEN NAME <u>Carrie Richardson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Clarence M. Gorrell, Churchville, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Carcinomatosis</u> DUE TO <u>170X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Adenocarcinoma L. Breast</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>18 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ASCD Ulcer</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>6-19</u> , 19 <u>67</u> , to <u>6-22</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>6-22</u> , 19 <u>67</u> , and that death occurred at <u>5:30</u> M. from causes and on the date stated above.			
22a. SIGNATURE <u>W.H. Sadowsky</u> M.D.		22b. DATE SIGNED <u>6/23/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>W.H. SADOWSKY</u>		22d. ADDRESS <u>504 Lewis St. Havre de Grace, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>June 24, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Methodist Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Calvary Harford Md</u>
24. FUNERAL DIRECTOR <u>Howard K. McComas & Son, Abingdon, Md. 21009</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>JUN 26 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

02234

Harford

Female White
Rebecca
Harford Memorial Hospital
4 days

Churchville
Box 541

June 22 67
Correll

Harford

Md

6-22-67
J. P. 3
J. 1-22-67

CERTIFICATE OF DEATH

08235

08222

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harve de Grace</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Hartford</u>	
c. LENGTH OF STAY IN lb <u>3 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Darlington</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hartford Memorial Hospital</u>		d. STREET ADDRESS <u>Rt 2 Box 172 A</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Alfred</u> First <u>Amos</u> Middle <u>Griffith</u> Last		4. DATE OF DEATH <u>June</u> Month <u>1</u> Day <u>19</u> Year <u>67</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC. 13, 1900</u>	9. AGE (In years last birthday) <u>66</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>STATE ROADS</u>		11. BIRTHPLACE (County & State, or foreign country) <u>SCARBORO, MD.</u>	
13. FATHER'S NAME <u>BARCHLEY GRIFFITH</u>		14. MOTHER'S MAIDEN NAME <u>MOLLIE REYNOLDS</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-09-0114</u>		17. INFORMANT <u>JOHN N. GRIFFITH, STREET, MD.</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> 4500 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>HEART ARTERIO SCLEROSIS</u> DUE TO (c) <u></u>					INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u> <u>5 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>Pneumonia</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>5/30</u> , 19 <u>67</u> to <u>6/1</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>6/1</u> , 19 <u>67</u> , and that death occurred at <u>5:45</u> AM, from causes and on the date stated above.					
22a. SIGNATURE <u>Dudley Phillips</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>6/2/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dudley Phillips MD</u>		22d. ADDRESS <u>Darlington MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>6-3-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>DARLINGTON</u>		23d. LOCATION (City or Town) (County) (State) <u>DARLINGTON, MD.</u>	
24. FUNERAL DIRECTOR <u>John H. Harkins, DELTA, PA.</u>		25a. REC'D BY REGISTRAR <u>JUN 6 1967</u> DATE		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

SECRET

RECEIVED 10/10/50

065330

TO: DIRECTOR, FBI
FROM: SAC, NEW YORK
SUBJECT: [Illegible]
[Illegible text follows, appearing to be a memorandum or report with several paragraphs of text that is mostly unreadable due to fading and bleed-through.]

10/10/50
[Illegible text in right margin]

FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNER.

VR A15ME (5)
6M 1/66

08236		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		08223	
1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Hartford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen Prov. Gd. DOA</u>		c. LENGTH OF STAY IN lb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Dodson Army Hospital</u>		d. STREET ADDRESS <u>RD 2</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William Hamby</u>		First Middle Last		4. DATE OF DEATH Month Day Year <u>June 19 1967</u>	
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
B. DATE OF BIRTH <u>3 April 1917</u>		9. AGE (In years last birthday) yrs. <u>50</u>		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Automotive Mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Edgewood Arsn. U.S. Govt.</u>		11. BIRTHPLACE (State or foreign country) <u>Harford County, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Edwin W. Hamby (D)</u>		14. MOTHER'S MAIDEN NAME <u>Eleanora Gross</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes WW-II</u>		16. SOCIAL SECURITY NO. <u>218-09-1544</u>		17. INFORMANT Address <u>Alice H. Hamby, Same as 2 C & D</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <u>4201</u> IMMEDIATE CAUSE (a) <u>coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Lorinda E Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> 6-14-67 ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Bel Air, Md. Address (Street, city, town, or county)			
EXAMINER'S NAME (Type) <u>Gerrid C Palmer MD</u>		22. DATE SIGNED			
23a. BURIAL, CREMATION, REMOVAL <u>Burial</u>		23b. DATE THEREOF <u>16 June 67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt Zion Cemetery</u>	
23d. LOCATION (City or Town) (County) (State) <u>Bel Air (Harford) Md.</u>					
24. FUNERAL DIRECTOR <u>Walter Macomber Jr.</u>		Tarring Funeral Home Aberdeen, Md.		25a. REC'D BY REGISTRAR <u>JUN 16 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED
DATE 11-11-01 BY 60322 UCBAW

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1-1-1

WILLIAM V. HANLEY
11/11/01

11-11-01

11-11-01

11-11-01

11-11-01

11-11-01

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

08237

CERTIFICATE OF DEATH

1. PLACE OF DEATH e. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bel Air		c. LENGTH OF STAY IN b 1 year		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bel Air			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 303 South Main Street				d. STREET ADDRESS 303 South Main Street			
3. NAME OF DECEASED (Type or print) First Robert Middle Stephen Last Harkins				4. DATE OF DEATH Month June Day 21 , Year 1967			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 5, 1909	9. AGE (In years last birthday) 58 yrs.	IF UNDER 1 YEAR Months 12 Days 1	IF UNDER 24 HRS. Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance		10b. KIND OF BUSINESS OR INDUSTRY Civil Service		11. BIRTHPLACE (County & State, or foreign country) Harford Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Nelson V. Harkins				14. MOTHER'S MAIDEN NAME Mary L. Skillman			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-03-5948		17. INFORMANT (Brother) 838-5370 Mr. Donald F. Harkins		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary artery disease DUE TO (c) Chr. arteriosclerotic cardiovascular disease 10 yrs PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Atrophic cirrhosis of liver	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour e.m. 19 p.m.	
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from May 1950 , 19 67 , to June 18 , 19 67 , that (I) (we) last saw the deceased alive on June 18, 1967 , and that death occurred at 7:00 P.M. on the causes and on the date stated above.	
22a. SIGNATURE Willard P. Hudson M.D.		22b. DATE SIGNED June 21, 1967		22c. PHYSICIAN'S NAME (Type) Willard P. Hudson, M.D.		22d. ADDRESS Forest Hill, Maryland 21050	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 23, 1967		23c. NAME OF CEMETERY OR CREMATORY Centre Meth. Cem.		23d. LOCATION (City, town or county) (State) Forest Hill, Harf. Co. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Joseph William Foster		24b. ADDRESS W. Broadway & Williams St. Bel Air, Maryland 21014		25a. REC'D BY REGISTRAR JUN 23 1967		25b. REGISTRAR'S SIGNATURE Charles J. [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

1883

Harford

Harford

Harford

1 mi. Air

1 year

1 mi. Air

303 South Main Street

303 South Main Street

Robert

Stephen

William

John

John

Male

White

X

April 5, 1902

58

Insurance

Life Service

Harford Co., Maryland

U.S.A.

John V. Perkins

John L. Perkins

(Formerly 83-2300)

212-02-2048 Mr. Donald E. Perkins

1 mi. Air, Maryland

10

Insurance

Insurance

Insurance

Insurance

Insurance

Insurance

January 1, 1907

X

Forrest Hill, Maryland

William F. Perkins, N.D.

Chief

James L. Perkins, Gen.

Forrest Hill, Md. Co. Md.

1 mi. Air, Maryland

1 mi. Air, Maryland

Joseph Perkins

08238

CERTIFICATE OF DEATH

08225

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVERDE GRACE</u>		c. LENGTH OF STAY IN lb <u>58 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HARFORD Memorial Hospital</u>				d. STREET ADDRESS <u>14 Aztec Rd. West</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>MARSHALL</u> Last <u>HARTMAN</u>				4. DATE OF DEATH Month <u>June</u> Day <u>29</u> Year <u>1967</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>16 Sept 1922</u>	
9. AGE (In years last birthday) <u>44</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Truck Rental</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Adams Co. Penna</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Lloyd R. Hartman</u>				14. MOTHER'S MAIDEN NAME <u>Nelle Mehring</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>WW II</u>		16. SOCIAL SECURITY NO. <u>160-16-3921</u>		17. INFORMANT <u>Vest Eppley</u> Address <u>14 Aztec St W. Aberdeen, Maryland 21001</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lesions in the right upper lobe of the lung</u> DUE TO (b) <u>etiology not determined</u> OUE TO (c) <u>after extensive evaluations in several hospitals</u> 5272						INTERVAL BETWEEN ONSET AND DEATH <u>> 3 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May 2</u> , 19 <u>67</u> , to <u>June 29</u> , 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>June 29</u> , 19 <u>67</u> , and that death occurred at <u>12:29 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Edward C. Loo, M.D.</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>6/29/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D.</u>				22d. ADDRESS <u>HAVERDE GRACE, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE THEREOF <u>Burial 2 July 67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Paddletown Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>New Berry, York Co., Pa</u>	
24. FUNERAL DIRECTOR <u>Walter W. Coulter Jr.</u>				ADDRESS <u>Tarring Funeral Home</u>		25a. REC'D BY REGISTRAR <u>JUN 30 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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to date 1922

Manager

Lloyd H. Harrison

John Harrison

Adams Co. Term

Yes

100-10-3021

Adams Co. Term

CERTIFICATE OF DEATH

08239

08226

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE DE GRACE DOA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE DE GRACE MD</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HARFORD MEMORIAL HOSP</u>		d. STREET ADDRESS <u>CHAPEL RD</u>	
3. NAME OF DECEASED (Type or print) <u>HAROLD</u> First Middle Last		4. DATE OF DEATH <u>JUNE 23</u> 19 <u>67</u> Month Day Year	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/20/1902</u> 65 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RESTAURANT RET</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SAME</u>	
13. FATHER'S NAME <u>Unk.</u>		14. MOTHER'S MAIDEN NAME <u>Unk.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>Unk.</u>	
17. INFORMANT <u>Lois M. Hensle</u> Address <u>Chapel Road Harford, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> <u>MINUTE</u> DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>DIABETES</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>JANUARY</u> , 19 <u>65</u> to <u>JUNE</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>JUNE 9</u> 19 <u>67</u> and that death occurred at <u>12:00</u> P.M. from causes and on the date stated above.			
22a. SIGNATURE <u>I. Randall Ross</u> M.D.		22b. DATE SIGNED <u>6/24/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>I. RANDALL ROSS, M.D.</u>		22d. ADDRESS <u>EIGHTON, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>6/26/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Angel Hill</u>	23d. LOCATION (City or Town) (County) (State) <u>Harford County, Md.</u>
24. FUNERAL DIRECTOR <u>Birmingham, Harford County, Md.</u>		25a. REC'D BY REGISTRAR <u>JUN 27 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF CALIFORNIA

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STATE OF CALIFORNIA

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08240

CERTIFICATE OF DEATH

08227

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY HARFORD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen Proving Gds.				c. LENGTH OF STAY IN 1b 17 Days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen, Md.				12. CITIZEN OF WHAT COUNTRY? USA			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kirk Army Hospital, Aberdeen PG, Md.				d. STREET ADDRESS 606 Webb St.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) SUSIE W. HERRING				4. DATE OF DEATH Month JUNE Day 24 Year 19 67			
5. SEX FEMALE		6. COLOR OR RACE CAU		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. AGE (In years last birthday) 22 June 1881 86 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (County & State, or foreign country) Calpepper, VA.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME RICHARD REVERCOMB				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT RICHARD HERRING, 606 Webb St. Aberdeen, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho Pneumonia DUE TO (b) 491X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 8 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerotic Cardiovascular Disease						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from 8 Jun 67 , to 24 June, 19 67 , that (I) (we) last saw the deceased alive on 26 June 19 67 , and that death occurred at 7:25 PM , from causes and on the date stated above.			
22a. SIGNATURE William J. Peter		22b. DATE SIGNED 24 June 67		22c. PHYSICIAN'S NAME (Type) WILLIAM J. PETER, CPT, MC		22d. ADDRESS Kirk Army Hospital, Aberdeen, PG, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal-Burial		23b. DATE THEREOF 6/27/67		23c. NAME OF CEMETERY OR CREMATORY Lewinsville Presbyterian		23d. LOCATION (City or Town) (County) (State) McClellan, Virginia	
24. FUNERAL DIRECTOR John G. Tarrington		25a. REC'D BY REGISTRAR Aberdeen, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge		DATE JUN 27 1967	

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WILLIAM H. HARRIS

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WILLIAM H. HARRIS

08241

CERTIFICATE OF DEATH

08228

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY HARFORD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAVRE DE GRACE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Joppa TOWN	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HARFORD Memorial Hosp.		d. STREET ADDRESS 789 Joppa Farm Road	
3. NAME OF DECEASED (Type or print) Chauncey Howard Hudeschel		4. DATE OF DEATH Month June Day 23 Year 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 4, 1895
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PIANO TUNER		10b. KIND OF BUSINESS OR INDUSTRY RETIRED	11. BIRTH PLACE (County & State, or foreign country) PA.
13. FATHER'S NAME WM. A. HODESHEL		14. MOTHER'S MAIDEN NAME SUSAN KOCHER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. 579-48-1927A	
17. INFORMANT Mr. NAOMI A. HODESHEL		Address 789 Joppa Farm Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction, post op DUE TO 5 days (b) Coronary thrombosis, right DUE TO 5 days (c) 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma right kidney & multiple metastases			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from JUNE 9, 1967 , to JUNE 23, 1967 , that (I) (we) lost the deceased on JUNE 23, 1967 , and that death occurred at 8:30 M., from causes on and on the date stated above.			
22a. SIGNATURE Richard J. Cofer		22b. DATE SIGNED 6/23/67	
22c. PHYSICIAN'S NAME (Type) RICHARD J. COFER		22d. ADDRESS HAVRE DE GRACE, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION	23b. DATE THEREOF 6-24-1967	23c. NAME OF CEMETERY OR CREMATORY LOODEN PARK CEM.	23d. LOCATION (City or Town) (County) (State) BALTIMORE MD.
24. FUNERAL DIRECTOR R. Madison Mitchell		25a. READ BY REGISTRAR JUL 6 1967	
ADDRESS HAVRE DE GRACE, MD.		25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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39539

RECEIVED

39539

General and right hand to master of the vessel

Richard P. [unclear]

X of [unclear]

08242

CERTIFICATE OF DEATH

08229

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Harford.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) R.D. # 2		d. STREET ADDRESS R.D. # 2 Box 368	
3. NAME OF DECEASED (Type or print) GEORGE H. JENKINS		4. DATE OF DEATH Month 6 Day 10 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 28, 1894
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months 12 Days 1 IF UNDER 24 HRS. Hours 12 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Life Ins.		11. BIRTHPLACE (County & State, or foreign country) Oregon	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME David Jenkins	
14. MOTHER'S MAIDEN NAME Ellen Royse		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW 1	
16. SOCIAL SECURITY NO. 216-05-6002		17. INFORMANT Mrs. Emily M. Jenkins, Aberdeen, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: 4201 White myocard. inf. IMMEDIATE CAUSE (a) _____ DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 4/3 19 67 , to 6/10 19 67 , that (I) (we) last saw the deceased alive on 6/10 19 67 , and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE [Signature]		22b. DATE SIGNED 6/12/67	
22c. PHYSICIAN'S NAME (Type) L.I. Mezei M.D.		22d. ADDRESS 601 S. Union Ave. H.d.G. Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 6/14/67	23c. NAME OF CEMETERY OR CREMATORY Gilpin Manor Memorial Park, Elkton, Md.	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL HOME FOR FUNERALS, ADDRESS Ralph E. Hicks		25a. REC'D BY REGISTRAR DATE JUN 23 1967	25b. REGISTRAR'S SIGNATURE [Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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08242

NATIONAL

Abandon

2.0.

Male White

Life Ins.

David Jenkins

on 1st

215-08-008 Mrs. W. L. Jenkins, Portland, Ore.

Allen Jones

Box 300

Abandon

July 20, 1964

Oregon

State of Oregon, for Franklin, Lincoln, Wyo. 100-2-1000

June 2, 1964

08243

CERTIFICATE OF DEATH

08230

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVERDE GRACE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Benson</u>	
c. LENGTH OF STAY IN 1b <u>10 days</u>		d. STREET ADDRESS <u>1901 Harford Rd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HOWARD</u> Middle <u>Andrew</u> Last <u>Kelly</u>		4. DATE OF DEATH Month <u>June</u> Day <u>12</u> Year <u>1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 6, 1914</u>
9. AGE (In years last birthday) <u>52</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Purchaser</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Aircraft</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Harford Co., Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William James Kelly</u>		14. MOTHER'S MAIDEN NAME <u>Bessie Agnes Wilgis</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>218-09-7259</u>	
17. INFORMANT (with) <u>838-7386</u> Address <u>Mrs. Anna E. Kelly 1901 Harford Rd. Benson, Maryland 21018</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Decompensation</u> DUE TO (b) <u>Extensive myocardial infarction</u> DUE TO (c) <u>Coronary thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>10 days</u> <u>10 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Diabetes Mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>June 3, 1967</u> to <u>June 12, 1967</u> , that (I) (we) last saw the deceased alive on <u>June 12, 1967</u> , and that death occurred at <u>4:30</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Edward C. Loo, M.D.</u>		22b. DATE SIGNED <u>6/12/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D.</u>		22d. ADDRESS <u>Haoverde Grace, Ind.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>JUNE 14, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. John's Cath. Ch. Cem.</u>	23d. LOCATION (City or town) (County) (State) <u>Long Green, Balto. Co., Maryland</u>
24. FUNERAL DIRECTOR <u>Joseph William Foster</u>		25a. REC'D BY REGISTRAR <u>JUN 14 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles J. ...</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

61237

CONTINUED OF 66411

17599

Diabetes Mellitus
Grossing of the stomach
Extensive ulcerated infection
Cancer of the stomach
+ day

Franklin D. Lee M.D.

Fluoride of the stomach
X

10-1-1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The permit remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08244

CERTIFICATE OF DEATH

08231

1. PLACE OF DEATH a. COUNTY HARFORD CITIZENS NURS. HOME HAVRE DE GRACE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWN c. LENGTH OF STAY IN 1b 6 wks d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) CITIZENS NURSING HOME		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY HARFORD c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BEL AIR d. STREET ADDRESS 116 LEXINGTON RD. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ADA Middle D Last KILE 4. DATE OF DEATH Month JUNE Day 11 Year 1967		5. SEX FEMALE 6. COLOR OR RACE WHITE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 6-27-01 9. AGE (In years lost birthday) yrs. 66 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker 10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) FORK, MD. 12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Samuel T. Beares 14. MOTHER'S MAIDEN NAME Elizabeth Schafferman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No 16. SOCIAL SECURITY NO. 214-20-0044 17. INFORMANT Family records		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 163X IMMEDIATE CAUSE (a) Generalized metastasis from lung cancer. st. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from Feb , 19 67 , to June 11 , 19 67 that (I) (we) last saw the deceased alive on June 11 , 19 67 and that death occurred at 2h M, from causes and on the date stated above.	
22a. SIGNATURE [Signature] M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED June 11-67		22c. PHYSICIAN'S NAME (Type) HENRY H. KWAK	
22d. ADDRESS 610 S. UNION AVE. HAVRE DE GRACE, MD		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 6/14/67 23c. NAME OF CEMETERY OR CREMATORY Parkwood Cem 23d. LOCATION (City or Town) (County) (State) Balto Md.	
24. FUNERAL DIRECTOR C.F. EVANS & SON ADDRESS 8802 Harford road		25a. REC'D BY REGISTRAR 14 1967 25b. REGISTRAR'S SIGNATURE [Signature]	

4422

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
Items #8 & 9 Film #G489 6/9/67 pc											
08245											
08232											
1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE DE GRACE</u>				c. LENGTH OF STAY IN 1b <u>9 hrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BELAIR</u>				12.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hosp.</u>						d. STREET ADDRESS <u>1 EAST ST.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Glen</u> First Middle Last						4. DATE OF DEATH <u>JUNE 3</u> 19 <u>67</u> Month Day Year					
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 26, 1909</u>		9. AGE (In years last birthday) yrs. <u>58</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Farmville, Pendleton Co., W. VA.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Okey Johnson Mauzy</u>						14. MOTHER'S MAIDEN NAME <u>SERENA Judy</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>220-07-8134</u>		17. INFORMANT with (838-2760) Address <u>Mrs. Norma M. Mauzy 1 EAST LEE Street Bel Air, Maryland 21014</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Decompensation</u> DUE TO <u>Arteriosclerotic Cardiovascular Disease</u> (b) <u>10 years</u> (c) <u>12 hours</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus, Abdominal aortic aneurysm</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>JUNE 3, 1967</u> , to <u>JUNE 3, 1967</u> , that (I) (we) last saw the deceased alive on <u>JUNE 3, 1967</u> , and that death occurred at <u>12:00</u> M, from causes on and on the date stated above.											
22a. SIGNATURE <u>Edward C. Loo, M.D.</u>						22b. DATE SIGNED <u>6/3/67</u>					
22c. PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D.</u>						22d. ADDRESS <u>Haure de Grace, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>JUNE 6, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>DEER CREEK Meth. Ch. Cem.</u>		23d. LOCATION (City or town) (County) (State) <u>Forest Hill, Harford Co., Maryland</u>					
24. FUNERAL DIRECTOR <u>Joseph William Foster</u> ADDRESS <u>W. Broadway & Williams St. Bel Air, Maryland 21014</u>						25a. REC'D BY REGISTRAR DATE <u>JUN 6 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			

2250

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08246

CERTIFICATE OF DEATH

08233

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>HARford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>HARford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE & GRACE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>	
c. LENGTH OF STAY IN 1b <u>35 days</u>		d. STREET ADDRESS <u>Paradise Road</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HARford Memorial Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Texie</u> Middle <u>ESTIE</u> Last <u>MAY</u>		4. DATE OF DEATH Month <u>June</u> Day <u>28</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 20, 1893</u>
9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Mountain City, Tenn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jacob May</u>		14. MOTHER'S MAIDEN NAME <u>Della Cornett</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>202-18-6267</u>	
17. INFORMANT <u>John May, Paradise Road, Aberdeen, Md.</u>		Address <u> </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO (b) <u>A.S.C.V. D</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State) <u> </u>
21. I certify that (I) (this hospital) attended the deceased from <u>MARCH</u> , 19 <u>67</u> , to <u>JUNE 28</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>JUNE 28</u> , 19 <u>67</u> , and that death occurred at <u>7:45</u> M., from causes and on the date stated above.			
22a. SIGNATURE <u>John D. Yun</u>		22b. DATE SIGNED <u>6/28/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN D. YUN</u>		22d. ADDRESS <u>HAURE & GRACE, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE THEREOF <u>June 28, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Gentry Funeral Home</u>	23d. LOCATION (City or Town) (County) (State) <u>Mountain City, Tenn.</u>
24. FUNERAL DIRECTOR <u>Howard K. McComas & Son, Abingdon, Md. 21009</u>		25a. REC'D BY REGISTRAR <u> </u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>JUN 30 1967</u>			

02520

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08247

CERTIFICATE OF DEATH

08234

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HARFORD GRACE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HARFORD MEMORIAL HOSPITAL</u>		d. STREET ADDRESS <u>409 W Belair Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Evelyn P. Miller</u>		4. DATE OF DEATH <u>June 6 1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/20/1901</u>
9. AGE (In years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		12. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
13. FATHER'S NAME <u>G. Robert Preston (D)</u>		14. MOTHER'S MAIDEN NAME <u>Annie Gerhardt (D)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>216-46-4716</u>	
17. INFORMANT <u>Sylvan Friedman</u>		Address <u>Balto Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Cardiovascular Disease</u> DUE TO (c) <u>Byrs.</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>3-22-</u> 19 <u>63</u> to <u>June 6</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>11-7-</u> 19 <u>66</u> , and that death occurred at <u>4:10</u> P.M., from causes and on the date stated above.			
22a. SIGNATURE <u>Peter P. Rodman</u>		22b. DATE SIGNED <u>6-8-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Peter P. Rodman, M.D.</u>		22d. ADDRESS <u>8 Law St. Aberdeen, Maryland</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>6/9/1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Baker Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Aberdeen (Harford) Md.</u>
24. FUNERAL DIRECTOR <u>Walter W. Weaver Jr.</u>		25a. REC'D BY REGISTRAR <u>JUN 9 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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EXHIBIT OF DATA

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3/20/1901

Weyland

Home

Home wife

at the 4th & 5th St. intersection

at the 4th & 5th St. intersection

6/1/1901

at the 4th & 5th St. intersection

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08248

08235

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen Proving Ground			c. LENGTH OF STAY IN 1b 1hr 48min			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kirk Army Hospital				d. STREET ADDRESS 14 Victory St.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Barbara Middle Lane Last Mills				4. DATE OF DEATH Month June Day 16 Year 1967			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 16, 1967		9. AGE (In years lost birthday) yrs. 1 48		IF UNDER 1 YEAR Months 1 Days 48
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A			10b. KIND OF BUSINESS OR INDUSTRY - - - -		11. BIRTHPLACE (County & State, or foreign country) Harford, Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Everett J. Mills				14. MOTHER'S MAIDEN NAME Harriet McCauley			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. -----		17. INFORMANT Father - Same as Above Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory arrest DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Lumbar meningomyelocele, ruptured DUE TO (c)							INTERVAL BETWEEN DEATH AND DEATH Birth "
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour 0 a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) did not attended the deceased from 16 June , 19 67 , to 16 June , 19 67 , that (I) did not saw the deceased alive on 16 June , 19 67 , and that death occurred at 10:30AM , from causes and on the date stated above.							
22a. SIGNATURE <i>Leland Wight</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 16 June 1967	
22c. PHYSICIAN'S NAME (Type) LELAND WIGHT, CPT, MC.				22d. ADDRESS Aberdeen Proving Ground, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Removal	17 June 67	Jerusalem Cemetery		Mill Creek, W. Virginia			
24. FUNERAL DIRECTOR <i>John L. Tarrington</i>				25a. REC'D BY REGISTRAR JUN 19 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
ADDRESS Aberdeen, Md.							

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and, of course, the *Journal of the American Medical Association*.¹

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08243

CERTIFICATE OF DEATH

02236

1. PLACE OF DEATH a. COUNTY <u>Citizens Nursing home</u> <u>Harford</u> <u>Havre de Grace</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Town</u>		c. LENGTH OF STAY IN 1b <u>3 months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rising Sun</u> <u>Rural</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Citizens Nursing Home</u>				d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Grover C. Ratliff</u> First <u>Cecil</u> Middle <u>Ratliff</u> Last				4. DATE OF DEATH Month <u>June</u> Day <u>27</u> Year <u>1967</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 17, 1988</u>		9. AGE (In years lost birthday) <u>78</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self Employed</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Pike County Kentucky</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>William Ratliff</u>					
14. MOTHER'S MAIDEN NAME <u>Armina Murphy</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>					
16. SOCIAL SECURITY NO. <u>406-36-5353</u>		17. INFORMANT <u>Vivienne Howell</u> <u>Rising Sun, Maryland</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-vascular accident</u> DUE TO (b) <u>Myocardial infarction</u> DUE TO (c) <u>Coronary atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>Sept 10, 1966</u> to <u>June 27, 1967</u> , that (I) (we) last saw the deceased alive on <u>June 26, 1967</u> , and that death occurred at <u>12:38</u> M, from causes and on the date stated above.					
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>6/27/67</u>		22c. PHYSICIAN'S NAME (Type) <u>G. H. Richards Jr MD</u>			
22d. ADDRESS <u>Port Deposit, Md.</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					
23b. DATE THEREOF <u>6-30-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Sword Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Pikeville Pike Ky.</u>			
23e. FUNERAL DIRECTOR <u>Samuel M. Mullen</u>		23f. REGISTRAR'S SIGNATURE <u>[Signature]</u>		23g. REGISTRAR'S NAME <u>Charles Judge</u>			

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DEPARTMENT OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #2c & d Film #G389 6/19/67 pc

CERTIFICATE OF DEATH

08250		08237	
1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NOTHINGHAM, Rural</u>	
c. LENGTH OF STAY IN lb <u>7 days</u>		d. STREET ADDRESS <u>Calvert Manor, Nottingham Rd</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>He Len</u> Middle <u>Reeder</u> Last <u>Reeder</u>		4. DATE OF DEATH Month <u>6</u> Day <u>9</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-19-1890</u>
9. AGE (In years last birthday) yrs. <u>76</u>		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>House Keeper, Domestic</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Cecil Co. Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Harry Buckley</u>	
14. MOTHER'S MAIDEN NAME <u>Mary Jane Buckley</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>218-52-3293 II</u>		17. INFORMANT <u>Mrs. Phleet Cooper Rising Sun, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Decompensation</u> DUE TO <u>Arteriosclerotic Cardiovascular Disease</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>?</u> (c) <u>?</u>		INTERVAL BETWEEN ONSET AND DEATH <u>one week</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Malnutrition</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>pm</u> 19 <u>67</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>6-2</u> , 19 <u>67</u> , to <u>6-9</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>6-9</u> , 19 <u>67</u> , and that death occurred at <u>4:30 PM</u> , from causes on and on the date stated above.			
22a. SIGNATURE <u>Edward C. Loo, M.D.</u>		22b. DATE SIGNED <u>6/9/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D.</u>		22d. ADDRESS <u>Harre-de-Grace, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>6-13-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Brookview Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Rising Sun, Cecil Md.</u>
24a. REC'D BY REGISTRAR <u>Wm. Muller, Rising Sun, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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EXPLAN OF DATA

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08251

CERTIFICATE OF DEATH

08238

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE de GRACE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BEL AIR (Rural)</u>	
c. LENGTH OF STAY IN 1b <u>9 days</u>		d. STREET ADDRESS (If not in hospital, give street address) <u>Box 334-1 RD 2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HARFORD MEMORIAL HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ANNE HARTENSE</u> First Middle Last		4. DATE OF DEATH Month <u>June</u> Day <u>12</u> Year <u>1967</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC. 25, 1886</u>
9. AGE (In years, last birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Homemaker</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>N.C. (Ashe County)</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ALFRED VANNOY</u>		14. MOTHER'S MAIDEN NAME <u>CYNTHIA BROWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>160-07-2385A</u>	
17. INFORMANT (Print name) <u>Mrs. Mary Louise Pimental</u>		18. ADDRESS <u>Box #2, Box #334-1 Bel Air, Maryland 21014</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarctus</u> DUE TO (b) <u>A.S.C.V.D</u> DUE TO (c) <u>Diabetes mellitus</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>JUNE 3, 1967</u> , to <u>JUNE 12, 1967</u> , that (I) (we) last saw the deceased alive on <u>JUNE 12, 1967</u> , and that death occurred at <u>12:50 P.M.</u> , from causes on and on the date stated above.			
22a. SIGNATURE <u>John D. Yun</u>		22b. DATE SIGNED <u>6/12/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN D. YUN</u>		22d. ADDRESS <u>HAURE de GRACE, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>JUNE 15, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>BEL AIR MEMORIAL GARDENS</u>	23d. LOCATION (City or Town) (County) (State) <u>BEL AIR, HARFORD CO, MARYLAND 21014</u>
24. FUNERAL DIRECTOR <u>Joseph William Foster</u>		25a. REC'D BY REGISTRAR <u>JUN 14 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and if convenient, within 72 hours after death.

08383

RECEIVED

08383

Handwritten notes and stamps are visible across the page, including a large circular stamp in the lower left corner and various illegible markings throughout.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08252

CERTIFICATE OF DEATH

08239

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HARFORD de Grace</u>		c. LENGTH OF STAY IN TB <u>22 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Abingdon</u> <u>21009</u> <u>12-1</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HARFORD Memorial Hospital</u>		d. STREET ADDRESS <u>Singer Road</u> <u>RT 1 - Box 4</u>	
3. NAME OF DECEASED (Type or print) <u>Dennis Kinsey Sanders</u>		4. DATE OF DEATH Month <u>June</u> Day <u>2</u> Year <u>1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/26/1886</u>
9. AGE (In years lost birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Rutledge, Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Alexander Sanders</u>	
14. MOTHER'S MAIDEN NAME <u>Sophie Stengel</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>215-03-9325</u>		17. INFORMANT Address <u>RD #1 Box 4</u> <u>Lillian M. Sanders Abingdon, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (g), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intestinal Hemorrhage</u> <u>541.0</u> DUE TO <u>Wardensal Ulcer</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO <u>Arteriosclerotic Disease</u> (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs</u> <u>1 wk</u> <u>6 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertrophic Pyloric Stenosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u> </u> , 19 <u> </u> , to <u> </u> , 19 <u> </u> , that (I) (we) last saw the deceased alive on <u>June 2</u> 19 <u>67</u> , and that death occurred at <u>4:45 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Ralph Horky</u>		22b. DATE SIGNED <u>6/5/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Ralph Horky</u>		22d. ADDRESS <u>Churchville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/5/1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Jarrettsville</u>		23d. LOCATION (City or Town) (County) (State) <u>Jarrettsville, Maryland</u>	
24. FUNERAL DIRECTOR <u>Charles E. Kurtz</u>		25a. REC'D BY REGISTRAR <u>JUN 5 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. REGISTRAR'S NAME <u>Charles Judge</u>	

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CERTIFICATE OF DEATH

08253

08240

1. PLACE OF DEATH a. COUNTY Harford b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural - Bel Air c. LENGTH OF STAY IN 1b 2 weeks d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Grafton Shop Road		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Florida b. COUNTY Broward c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Lauderdale d. STREET ADDRESS 519 N.W. 48 Court e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Cora E. Senior		4. DATE OF DEATH Month June , Day 9 , Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 24, 1885
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Homemaker	
11. BIRTHPLACE (County & State, or foreign country) Sandusky, Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Emrich		14. MOTHER'S MAIDEN NAME Emily Lange	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give year or dates of service)		16. SOCIAL SECURITY NO. 294-30-9296B	
17. INFORMANT (Husband) Mr. William L. Senior		18. ADDRESS 519 N.W. 48 Court Ft. Lauderdale, Fla.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable stroke or myocardial infarction 4500 DUE TO Conditions, if any, which gave rise to immediate cause (b) Arteriosclerosis (a), stating the underlying cause last. DUE TO (c) Old age.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchitis - probable bronchopneum.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from 6/6, 1967 to 6/9, 1967 , that (I) (we) last saw the deceased alive on 6/7, 1967 , and that death occurred at 7 P.M. from the causes and on the date stated above.	
22a. SIGNATURE Vincent R. Moloney M.D.		22b. DATE SIGNED June 9, 1967	
22c. PHYSICIAN'S NAME (Type) Vincent R. Moloney, M.D.		22d. ADDRESS Bel Air, Maryland 21014	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF June 12, 1967	23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens	23d. LOCATION (City, town or county) Bel Air, Harf. Co., Maryland
24. FUNERAL DIRECTOR'S SIGNATURE Joseph William Foster		25. REC'D BY REGISTRAR W. Broadway & Williams St. Bel Air, Maryland 21014	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE JUN 12 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08254

08241

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace		c. LENGTH OF STAY IN lb DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Darlington			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Harford Memorial Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ronald Middle Wayne Last Singleton				4. DATE OF DEATH Month June Day 11 Year 1967			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 21, 1950	9. AGE (In years last birthday) yrs. 16	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Havre de Grace, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Calvin D. Singleton				14. MOTHER'S MAIDEN NAME Fern Mellon			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 219-56-3763		17. INFORMANT Fern M. Singleton, Darlington, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 929.9 Asphyxia due to Drowning IMMEDIATE CAUSE (a) Asphyxia due to Drowning DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Drowned					
20c. TIME OF INJURY Month, Day, Year Hour 3 p.m. 6-11 19 67		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Darlington Hq. Md.		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Dorothy C Palmer M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> Bel Air, Md.			
EXAMINER'S NAME (Type) Gerold C Palmer - M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 6-11-67			
				Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 14, 1967		23c. NAME OF CEMETERY OR CREMATORY Darlington Cemetery		23d. LOCATION (City or Town) (County) (State) Darlington Harford Md	
24. FUNERAL DIRECTOR Howard K. McComas & Son, Abingdon, Md. 21009				25a. REC'D BY REGISTRAR JUN 14 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

18525

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
Harford County											
CERTIFICATE OF DEATH											
08242											
1. PLACE OF DEATH a. COUNTY <u>Harford de Grace</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Citizens Nursing Home</u>				c. LENGTH OF STAY IN 1b <u>73 DAYS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u> <u>12-1</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Mary's</u>						d. STREET ADDRESS <u>Stephens RD #2 Box 318</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MARY</u> First <u>IRENE</u> Middle <u>STEPHENS</u> Last						4. DATE OF DEATH Month <u>6</u> Day <u>1</u> Year <u>1967</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-12-1895</u>		9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MD</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE H. WHITE</u>						14. MOTHER'S MAIDEN NAME <u>SARAH F. GATES</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes give war or dates of service) <u> </u>				16. SOCIAL SECURITY NO. <u>213-48-7821</u>		17. INFORMANT <u>Mr. Malcolm E. STEPHENS</u>				Address <u>ABERDEEN, MD</u> <u>R.D. #2 Box 318</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cornary Thrombosis</u> DUE TO <u>4201</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO <u> </u> (c) <u> </u>										INTERVAL BETWEEN ONSET AND DEATH <u>4 1/2 hours</u> <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u> </u> , 19 <u> </u> , to <u> </u> , 19 <u> </u> , that (I) (we) last saw the deceased alive on <u> </u> 19 <u> </u> , and that death occurred at <u> </u> M, from causes and on the date stated above.											
22a. SIGNATURE <u>Mahmoud M</u>						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>M. W. ISHAK, M.D.</u>						22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>JUNE 5, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>HARMONY Pres. Church Yd. Harford Co.</u>				23d. LOCATION (City or Town) (County) (State) <u>MD</u>	
24. FUNERAL DIRECTOR <u>R. Madison Mitchell</u>						25a. REC'D BY REGISTRAR <u>Harford Co. Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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HEAD IN HAND

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08256

CERTIFICATE OF DEATH

08243

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY HARFORD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ABERDEEN				c. LENGTH OF STAY IN 1b 1 DAY			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) KIRK ARMY HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First RAYMOND Middle G. Last STOCKNER				4. DATE OF DEATH Month JUNE Day 18 Year 19 67			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 20 DEC 1946	
9. AGE (In years lost birthday) yrs. 20		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SOLDIER		11. BIRTHPLACE (County & State, or foreign country) PORTSMOUTH, OHIO.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME RAYMOND STOCKNER				14. MOTHER'S MAIDEN NAME MARIE BAUER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES 7-Dec-66, 18 Jun 67. UNK				17. INFORMANT US ARMY PERSONNEL RECORDS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crushing of skull, broken neck, & face bones, DUE TO (b) Multiple internal injuries chest, abdomen, pelvis, DUE TO (c) Open wounds, multiple site.							INTERVAL BETWEEN ONSET AND DEATH immediate
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) WAS ALLEGEDLY STRUCK BY A TRAIN			
20c. TIME OF INJURY Month, Day, Year 1230 Hour a.m. Jun 18 19 67		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Railroad crossing		20f. (City or town) (County) (State) Aberdeen Harford Md.	
21. I certify that (I) (this hospital) attended the deceased from 18 June , 19 67 , to 18 June , 19 67 that (I) (we) last saw the deceased alive on DOA, 18 Jun 19 67 , and that death occurred at 1230AM , from causes and on the date stated above.							
22a. SIGNATURE Thomas Fraher M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 18 June 67	
22c. PHYSICIAN'S NAME (Type) THOMAS FRAHER, M.D.				22d. ADDRESS Kirk Army Hospital, RPG, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 6/21, 1967		23c. NAME OF CEMETERY OR CREMATORY St. Peter's Catholic Cem. Wheelersburg, Ohio		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR Lee A. Patterson & Son, Perryville, Maryland				25a. REC'D BY REGISTRAR JUN 26 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

1935

08326

Received of the Treasurer of the State of Ohio
for the year 1935
the sum of \$100.00
for the purpose of the purchase of land
for the use of the State of Ohio
this 1st day of January 1935

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08257

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08244

1. PLACE OF DEATH a. COUNTY <u>Hanford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Hanford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Norrisville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Norrisville</u> 12-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Center Church Road</u>		d. STREET ADDRESS <u>Center Church Road</u>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>E</u> Last <u>Stewartbridge</u>		4. DATE OF DEATH Month <u>June</u> Day <u>5</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/25/1896</u>
9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>York Co., Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John W. Strawbridge</u>		14. MOTHER'S MAIDEN NAME <u>Mary Kate Groh</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>183-14-8984</u>	
17. INFORMANT <u>John E. Strawbridge, Stewartstown, Pa.</u>		Address <u>Pa.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Suicide by hanging</u> 974X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Hanged self in barn</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>6-5</u> p.m. <u>19</u> <u>67</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Barn</u>		20f. (City or town) (County) (State) <u>Norrisville</u> <u>Pa.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald P. Palmer</u> M.D.		22. DATE SIGNED <u>6-5-67</u>	
EXAMINER'S NAME (Type) <u>Gerald P. Palmer</u>		Address (Street, city, town, or county) <u>Stewartstown, Penna.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/8/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Centre Presby. Cem. New Park, York Co. Penna.</u>		23d. LOCATION (City or Town) (County) (State) <u>Stewartstown, Penna.</u>	
24. FUNERAL DIRECTOR <u>Kenneth W. Osburn</u>		25a. HEALTHY REGISTRAR <u>JUN 7 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Gerald P. Palmer</u>		25c. REGISTRAR'S SIGNATURE <u>Gerald P. Palmer</u>	

52804

100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08258

CERTIFICATE OF DEATH

08245

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen Proving Gds.</u>		c. LENGTH OF STAY IN 1b <u>31 Days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kirk Army Hospital, Aberdeen PG, Md.</u>		d. STREET ADDRESS <u>347 Graceford Dr.</u>	
3. NAME OF DECEASED (Type or print) <u>Gilbert</u> <u>Sturtevant</u>		4. DATE OF DEATH Month <u>June</u> Day <u>19</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>13 Aug. 1918</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Soldier</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Army</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Holtsville, Calif.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Elbert Julian Sturtevant</u>		14. MOTHER'S MAIDEN NAME <u>Laura Long</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>1941 - 1966</u>		16. SOCIAL SECURITY NO. <u>568-05-9643</u>	
17. INFORMANT <u>Mrs. Grace E. Sturtevant, Aberdeen, Maryland</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO (c) <u>31 Days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>o.m.</u> <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>19 May</u> , 19 <u>67</u> , to <u>19 June</u> , 19 <u>67</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>19 June</u> 19 <u>67</u> , and that death occurred at <u>0305 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Thomas Fraher M.D.</u>		22b. DATE SIGNED <u>19 June 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>THOMAS FRAHER, M.D.</u>		22d. ADDRESS <u>Kirk Army Hospital, Aberdeen PG, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>22 June 67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		23d. LOCATION (City or Town) (County) (State) <u>Fort Meyer, Virginia</u>	
24. FUNERAL DIRECTOR <u>Walter Macomber Jr.</u>		25a. REC'D BY REGISTRAR <u>JUN 23 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

08258

DEPARTMENT OF DEATH

Hepp

8 18

25 June of Arlington National Cemetery
Burial Home
Arlington, Va.

CERTIFICATE OF DEATH

08259

08248

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford-de-Grace</u>		c. LENGTH OF STAY IN lb <u>28 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>		d. STREET ADDRESS <u>1410 Cherokee Lane</u>	
3. NAME OF DECEASED (Type or print) <u>Lois Rembold Thomas</u>		4. DATE OF DEATH <u>6</u> Month <u>3</u> Day <u>1967</u> Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 26, 1929</u>
9. AGE (In years last birthday) <u>37</u> yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House-wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Homemaker</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Md. (Balto. Co.)</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John F. Rembold</u>		14. MOTHER'S MAIDEN NAME <u>Jennie Charles</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>218-26-6918</u>	
17. INFORMANT <u>Husband (838-5552)</u> Address <u>P.O. Box 4707 BEL Air, Md. 21014</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic Coma and Hepatorenal Syndrome</u> DUE TO (b) <u>Laennec's Cirrhosis of liver</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>6 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>5-5</u> , 19 <u>67</u> to <u>6-3</u> , 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>6-3</u> 19 <u>67</u> , and that death occurred at <u>9:30 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Edward C. Loo, M.D.</u>		22b. DATE SIGNED <u>6/3/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D.</u>		22d. ADDRESS <u>Harford-de-Grace, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>June 7, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Meth. Ch. Cem.</u>	23d. LOCATION (City or town) (County) (State) <u>BEL Air, Harford Co., Maryland 21014</u>
24. FUNERAL DIRECTOR <u>Joseph William Foster</u> ADDRESS <u>W. Broadway & Williams St. BEL Air, Maryland 21014</u>		25a. REC'D BY REGISTRAR <u>JUN 6 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

2258

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08260

CERTIFICATE OF DEATH

08247

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford-de-B-race</u>		c. LENGTH OF STAY IN lb <u>2 1/2 mos.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>		d. STREET ADDRESS <u>Rt. 2.</u>	
3. NAME OF DECEASED (Type or print) <u>Harry William Tobin</u>		4. DATE OF DEATH Month <u>6</u> Day <u>8</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 19, 1893</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer Retired.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>	11. BIRTHPLACE (County & State, or foreign country) <u>md. (Balt. City)</u>
13. FATHER'S NAME <u>Harry William Tobin</u>		14. MOTHER'S MAIDEN NAME <u>Kate (Tobin) Patton</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>212-16-0318</u>	
17. INFORMANT (with) <u>734-7368</u> Address <u>Box # 296 Churchville, Maryland</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis, Pneumonia</u> <u>154X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Far advanced Ca of Rectum</u> DUE TO (c) <u>with incontinence & debility</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>4-29</u> , 19 <u>67</u> , to <u>6-8</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>6-8</u> , 19 <u>67</u> , and that death occurred at <u>5:34</u> A.M. from causes and on the date stated above.			
22a. SIGNATURE <u>N. W. ISHAK, M.D.</u>		22b. DATE SIGNED <u>June 8, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>N. W. ISHAK, M.D.</u>		22d. ADDRESS <u>504 Lewis Street Harford, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>June 10, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Ignatius Church Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Hickory, Harf. Co., Md.</u>
24. FUNERAL DIRECTOR <u>Joseph William Foster</u>		25a. REC'D BY REGISTRAR <u>JUN 12 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

1556

REPORT OF DEATH

00330

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE AT DEATH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

Marital Status

Number of Children

Number of Siblings

Number of Grandchildren

Number of Great-Grandchildren

Number of Great-Great-Grandchildren

Number of Great-Great-Great-Grandchildren

Number of Great-Great-Great-Great-Grandchildren

Number of Great-Great-Great-Great-Great-Grandchildren

Number of Great-Great-Great-Great-Great-Great-Grandchildren

Number of Great-Great-Great-Great-Great-Great-Great-Grandchildren

REPORT BY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08261

CERTIFICATE OF DEATH

08248

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u> Cecil </u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAUCE DE GRACE</u>		c. LENGTH OF STAY IN 1b <u>16 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Port Deposit</u>		d. STREET ADDRESS <u>32 N. MAIN</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HARFORD MEMORIAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>WALTER</u> First Middle Last		4. DATE OF DEATH <u>Todd Jr.</u> Month Day Year <u>JUNE 13</u> 19 <u>67</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 22, 1911</u> 55 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maintenance Supervisor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>H. P. G.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Walter Todd Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Alvia E. Thomas</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>1942-1945</u>		16. SOCIAL SECURITY NO. <u>217-07-5888</u>	
17. INFORMANT <u>Mrs. Caroline T. McFall, Port Deposit, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>5410</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Post operative Gastric Resection</u> (c) <u>Bleeding Duodenal Ulcer</u>		INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u> <u>7 days</u> <u>10 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>28 May, 1967</u> , to <u>June 13, 1967</u> that (I) (we) last saw the deceased alive on <u>June 13, 1967</u> , and that death occurred at <u>10 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>W.H. Sadowsky</u>		22b. DATE SIGNED <u>6/13/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>W.H. SADOWSKY</u>		22d. ADDRESS <u>504 LEWIS ST. HAUCE DE GRACE</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>June 16, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>West Nottingham Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Colona, Maryland.</u>
24. FUNERAL DIRECTOR <u>Lee A. Patterson & Son, Perryville, Md.</u>		25a. REC'D BY REGISTRAR <u>JUN 26 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

8338

1033

11-1-42 217-7-282 Mrs. Caroline J. Kelly, Westchester, N.Y.
Robert John M.
William C. Johnson, N.Y.C.
Nov. 2, 1942

Nov 16, 1942
100 N. Michigan Ave., Detroit, Mich.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08262

CERTIFICATE OF DEATH

08249

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harpe-de-Grace</u>		c. LENGTH OF STAY IN lb <u>8 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Darlington</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>		d. STREET ADDRESS <u>R.D. #2 Box 308</u>	
3. NAME OF DECEASED (Type or print) <u>Roby Franklin Wallace</u>		4. DATE OF DEATH Month <u>6</u> Day <u>16</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 4, 1877</u>
9. AGE (In years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR Months <u>16</u> Days <u>19</u> Hours <u>67</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Tenn.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Elkanah Wallace</u>	
14. MOTHER'S MAIDEN NAME <u>Elizabeth Arnold</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>212-32-4522</u>		17. INFORMANT <u>Paul Raywood Wallace</u> Address <u>somewhere above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> 331X DUE TO (b) <u>Arterio sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>8 Days</u> <u>9 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>June 6</u> , 19 <u>67</u> , to <u>June 16</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>6/16/67</u> 19 <u>67</u> , and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE <u>Dudley Phillips</u>		22b. DATE SIGNED <u>6/17/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dudley Phillips MD</u>		22d. ADDRESS <u>Darlington Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>JUNE 20, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>WILSON</u>	23d. LOCATION (City or Town) (County) (State) <u>MOUNTAIN CITY, TENN.</u>
24. FUNERAL DIRECTOR <u>John H. Harkins, DELTA, PA.</u>		25a. REC'D BY REGISTRAR <u>JUN 20 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and to any event, within 72 hours after death.

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CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u>		c. LENGTH OF STAY IN lb <u>10 hrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hartford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Abram Smith Wilson</u>		4. DATE OF DEATH Month Day Year <u>June 11, 1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APR. 9, 1900</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BRIDGE DEPT.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>STATE ROADS COMM.</u>	11. BIRTHPLACE (County & State, or foreign country) <u>N. J.</u>
13. FATHER'S NAME <u>FRANCIS WILSON</u>		14. MOTHER'S MAIDEN NAME <u>IDA HOFF</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>YES WORLD WAR I 1918-19</u>		16. SOCIAL SECURITY NO. <u>705-03-9210</u>	
17. INFORMANT <u>MRS. MARGARET G. WILSON</u>		Address <u>631 ONTARIO ST. HAVRE DE GRACE, MD.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }			INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>6-11</u> , 19 <u>67</u> , to <u>6-11</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>6-11</u> , 19 <u>67</u> , and that death occurred at <u>11 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Ross Z. Pierpont</u>		22b. DATE SIGNED <u>June 12, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Ross Z. Pierpont MD</u>		22d. ADDRESS <u>665 Union Ave Havre de Grace</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>JUNE 14, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ANGEL HILL CEM.</u>	23d. LOCATION (City or Town) (County) (State) <u>HAVRE DE GRACE MD.</u>
24. FUNERAL DIRECTOR <u>R. MADISON MITCHELL</u>		25a. RECEIVED BY REGISTRAR <u>JUN 14 1967</u>	
ADDRESS <u>HAVRE DE GRACE, MD.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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CONFIDENTIAL REPORT

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CONFIDENTIAL